STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility reported a census of 30 residents. Based on observation and interview, the facility failed to label personal care items for 1 of 1 day on site of survey and failed to provide a comfortable and clean environment for 2 of 4 days on site of survey for some resident rooms and common areas. Findings included: - On 10/29/14 at 3:07 P.M. revealed unlabeled personal care items sat on the sinks of 3 unsampled residents. On 11/3/14 at 4:00 P.M. direct care staff Q stated certified nursing aides (CNA) labeled and ensured resident personal care items were labeled. On 11/4/14 at 9:29 A.M. administrative nursing staff D stated any staff member should ensure resident personal care items were labeled. On 11/4/14 at 9:42 A.M. licensed nursing staff H stated CNAs labeled resident personal care items. The facility failed to ensure resident's personal	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 care items were labeled. - On 10/29/14 at 1:30 P.M. to 5:00 P.M. and on environmental tour on 11/4/14 at 10:20 A.M. to 10:50 A.M. with housekeeping/maintenance staff X and Y revealed the following: The main resident hallway revealed a bathroom with mismatched paint around a paper towel holder, dirty floors in resident rooms along the base boards, base boards were pulled away from the walls in a resident's bathroom, holes in the walls in a resident's bathroom, dirty bathroom walls, cracked/peeling/missing paint on a bathroom grab bars. The resident shower/whirlpool room had a dirty floor. The locked nursing station revealed the base board was missing, holes in the wall, dirty walls, and frayed carpet. The resident phone booth had a dirty floor and walls, the base board was peeling away from the wall, and had a hole in the door covered with gray duct tape. Throughout the environmental tour on 11/4/14 maintenance/housekeeping staff X and Y acknowledged the above concerns. The facility failed to provide a policy for the general maintenance of the facility. The facility failed to maintain a clean and comfortable environment for the residents.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 2 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by:	F 272		

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F 272	Continued From page 3	F 272		

The facility identified a census of 30 residents. The sampled included 12 residents. Based on observation, record review, and interview the facility failed to complete all triggered Care Area Assessments for 1 (#20) sampled resident.

Findings included:

- The admission Minimum Data Set (MDS) dated 4/3/14 for resident #20 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. He/she was independent with activities of daily living (ADLs) and was steady at all times.

The MDS section V revealed the Care Area Assessment (CAA) for ADLs tirggered for staff to complete. Review of the CAAs showed staff failed to complete the ADL CAA.

Observation on 11/3/14 at 7:55 A.M. revealed the resident walked independently carrying his/her tray from breakfast and returned it to the kitchen staff.

Interview on 11/4/14 at 8:41 A.M. with licensed nursing staff H revealed the director of nursing completed the MDS and CAAs. Staff H reported he/she expected the MDS to be completed.

Interview on 11/4/14 at 10:32 A.M. with administrative nursing staff D revealed he/she acknowledged the facility had concerns regarding completion of the MDS. Staff D should complete all triggered CAAs.

The undated policy provided by the facility regarding the MDS revealed the facility conducted comprehensive assessments according to federal regulations and Medicare guidelines. The facility

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F 272	Continued From page 4 staff followed current Resident Assessment Instrument manual for proper procedures on completing the MDS. The facility failed to complete the triggered ADL CAA for this sampled resident.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents. Based upon observation, record review and interviews the facility failed to complete comprehensive assessments within 14 days of a resident's admission for 3 (#34, #29 and #35) sampled residents. Findings included: - Resident #35's admission Minimum Data Set (MDS) dated 3/1/14 identified the resident was admitted to the facility on 2/21/14. Review of the CAA Summary revealed the Registered Nurse completed the Care Area Process on 3/29/14 (duration greater than 14 days days after admission). On 11/4/14 at approximately 9:45 A.M. direct care	F 273		

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F 273	Continued From page 5	F 273		

staff Q transferred the resident from the wheelchair to his/her bed. Observation revealed the resident had a slow and unsteady gait and the resident's right foot was shorter than his/her left foot.

On 11/4/14 at 10:30 A.M. administrative nursing staff D confirmed the comprehensive assessment was not completed within 14 days of the resident's admission.

The facility's undated Minimum Data Set (MDS) policy and procedure included the facility conducted comprehensive assessment (MDS) according to Federal regulations and Medicare guidelines.

The facility failed to complete the comprehensive assessment within 14 days of the resident's admission.

- Resident #29's Admission Minimum Data Set (MDS) dated 2/1/14 identified the resident was admitted to the facility on 1/24/14 and was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use and personal hygiene.

Review of the resident's Fall Care Area Assessment (CAA) dated 3/15/14 included the resident did not have a history of falls.

Review of the CAA Summary revealed the Registered Nurse completed the Care Area Process on 3/15/14 (duration greater than 14 days days after admission).

The resident was transferred to the hospital on 10/31/14.

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F 273	Continued From page 6 On 11/4/14 at 10:30 A.M. administrative nursing staff D confirmed the comprehensive assessment was not completed within 14 days of the resident's admission. The facility's undated Minimum Data Set (MDS) policy and procedure included the facility conducted comprehensive assessment (MDS) according to Federal regulations and Medicare guidelines. The facility failed to complete the comprehensive assessment within 14 days of the resident's admission as required. - The Admission Minimum Data Set (MDS)for resident #34 was dated 2/21/14. The Dental Care Area Assessment (CAA) was dated 3/30/14. On 11/3/14 at 12:00 P.M. the resident ate her/his noon meal without chewing difficulties. On 11/4/14 at 9:29 A.M. administrative nursing staff D stated the CAA should have been completed in a timely manner. The undated policy and procedure titled Minimum Data Set revealed the facility would conduct a comprehensive assessment according to Federal regulations and Medicare guidelines. The facility failed to complete the admission CAA in a timely manner for this resident as required.	F 273		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 7 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 30 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a comprehensive care plan for 2 sampled residents, (#34) resident for dental service, and 1(#29) for insomnia (inability to sleep) and constipation (difficulty passing stools). Findings included: - The quarterly Minimum Data Set (MDS) dated 10/15/14 for resident #34 revealed a Brief interview for Mental Status (BIMS) score of 15 (cognitively intact). The resident was independent with for bed mobility, transfers, walking in her/his	F 279		

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F 279	Continued From page 8 room/corridor, locomotion on/off the unit,eating, and personal hygiene. The admission MDS dated 2/21/14 revealed a BIMS score of 15 (cognitively intact). The resident was independent without set up with for bed mobility, transfers,walking in her/his room/corridor, locomotion on/off the unit, eating, and personal hygiene. The resident had cavities or broken natural teeth, inflamed or bleeding gums or loose natural teeth, and mouth or facial pain, discomfort, or difficulty with chewing. The Dental Care Area Assessment (CAA) dated 3/30/14 revealed the resident experienced mouth and tooth pain, had a cavity and swollen gums. The resident would see the physician for assessment and staff would care plan and monitor the resident's dental/oral status. The care plan updated on 10/11/14 revealed the resident was independent with her/his own personal needs. The resident did not require assistance with her/his shower or with bathing and preferred to shower in the morning. The care plan dated 10/11/14 lacked documentation for dental services. On 11/3/14 at 12:00 P.M. the resident ate her/his noon meal without chewing difficulties. On 11/4/14 at 9:29 A.M. administrative nursing staff D stated the care plan should include dental services. On 11/4/14 at 9:42 A.M. licensed nursing staff H stated administrative nursing staff D completed the comprehensive care plans.	F 279		

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F 279	Continued From page 9 The undated policy and procedure titled Comprehensive Care Plan revealed it was the facility would develop a comprehensive care plan for each resident that included measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs and were consistent with the resident's desires and preferences. The facility failed to provide a comprehensive dental care plan for this resident with a history of dental concerns. - Resident #29's computerized diagnoses included the resident had a diagnosis of constipation (infrequent or hard to pass bowel movements) and insomnia (difficulty sleeping). The resident's quarterly Minimum Data Set (MDS) dated 9/24/14 included the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use and personal hygiene. The MDS identified the resident received antipsychotic, antidepressant and antianxiety medication 7 of 7 days during the assessment period. The resident's Antipsychotic Care Area Assessment dated 3/15/14 included the resident received antipsychotic, antianxiety, and antidepressant medications and staff monitored the resident for side effects of the medications	F 279		

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F 279	Continued From page 10 each shift. The resident's care plan dated 7/7/14 addressed the resident received psychotropic medications and staff administered the medications as physician ordered. Staff monitored and documented if the resident experienced side effects from the medications including constipation. The resident's care plan did not include interventions for constipation or insomnia. Review of the resident's current computerized physician's orders revealed or medications Trazadone 75 mg daily for insomnia and Colace (used to treat constipation) 100 mg two times a day. The resident transferred from the facility on 10/31/14. On 11/4/14 at 7:57 A.M. administrative nursing staff D confirmed the resident's care plan did not include sleep hygiene interventions related to the resident's insomnia. On 11/4/14 at 10:30 A.M. administrative nursing staff D confirmed the resident's care plan did not address constipation. The facility's undated Comprehensive Care Plan Policy and Procedure included the facility monitored care plans on an on-going basis to ensure the care plan reflected the resident's current status and revised care plans as needed. The facility failed to develop a comprehensive care plan that included interventions that addressed the resident's insomnia and constipation.	F 279		

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F 280	Continued From page 11	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents. Based upon observation, record review and interview the facility failed to revise 1 (#35) resident's care plan to include the resident's toileting program. Findings included: - Resident #35's admission Minimum Data Set (MDS) dated 3/1/14 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, was independent with bed mobility, transfers, locomotion on/off unit, walking room/corridor, eating, toilet use, dressing,	F 280		

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personal hygiene and the resident's gait was steady at all times. The MDS identified the resident was always continent of urine.

The resident quarterly Minimum Data Set (MDS) dated 10/29/14 identified the resident scored 12 (moderate impaired cognition) on the Brief Interview for Mental Status, required limited staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident had an unsteady gait and was only able to stabilize with staff assistance when moved from a seated to a standing position, walking, turning around, moving on/off the toilet and surface to surface transfers The MDS identified the resident had (2) non-injury falls since the prior assessment and was occasionally incontinent of urine and received an antidepressant, antipsychotic and antianxiety 7 of the 7 days during the assessment period.

The resident's Activity of Daily Living and Urinary Status Care Area Assessments did not trigger.

The resident's care plan dated 8/7/14 included the resident was at an increased risk of falling due to weakness and an unsteady gait at times. The resident could not safely ambulate with his/her walker and the staff assisted the resident with ambulation via a gait belt to help keep him/her mobile and safe from injury. The resident used a wheelchair the majority of the time to get around which he/she self propelled but staff assisted the resident if he/she was tired or needed to get somewhere quickly. An entry dated 9/30/14 included at times the resident went to the bathroom without asking for staff assistance and staff followed the resident's

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F 280	Continued From page 13 specific toileting plan. The resident's care plan did not include the resident's specific toileting program nor did it direct staff where the resident's specific toileting program was located. A nurse's note dated 9/30/14 timed and timed 7:54 P.M. included the resident was on the floor. The resident stated he/she attempted to get from the bathroom to the bed, he/she could not reach the bed and fell down. Recommendation included nursing staff was to follow the resident's specific toileting program to help reduce falls. A nurses's note dated 10/24/14 and timed 5:42 P.M. included the resident was incontinence of bladder at times and was not on a bowel or bladder program. The resident's clinical record did not support the facility performed a 3 day voiding diary or a bladder assessment. The resident refused to allow the surveyor to observe his/her personal cares. On 11/4/14 direct care staff Q transferred the resident from the wheelchair to his/her bed. Observation revealed the resident had a slow and unsteady gait and the resident's right foot was shorter than his/her left foot. On 11/4/14 at 7:57 A.M. administrative nursing staff D stated the resident was occasionally incontinent of urine and staff toileted the resident every 2 hours and as needed. Administrative nursing staff D confirmed the resident's care plan did not include the resident's specific toileting program.	F 280		

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F 280	Continued From page 14 The facility's undated Comprehensive Care Plan Policy and Procedure included the facility monitored care plans on an on-going basis to ensure the care plan reflected the resident's current status and revised care plans as needed. The facility failed to update the resident's care plan to include the resident's specific toileting program for this resident who was continent of bladder when admitted to the facility and had a change in continency.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents. Based upon observation, record review, and interview the facility failed to thoroughly assess 1 of 1 resident sampled for incontinence, (#35) resident's urinary status to develop an individualized toileting program and to restore as much normal bladder function as possible. Findings included: - Resident #35's admission Minimum Data Set	F 315		

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(MDS) dated 2/1/14 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, was independent with bed mobility, transfers, locomotion on/off unit, walking in room/corridor, eating, toilet use, dressing, personal hygiene and the resident's gait was steady at all times. The MDS identified the resident was always continent of urine.

The quarterly Minimum Data Set (MDS) dated 10/29/14 identified the resident scored 12 (moderately impaired cognition) on the Brief Interview for Mental Status, required limited staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident had an unsteady gait and was only able to stabilize with staff assistance when moved from a seated to a standing position, walking, turning around, moving on/off the toilet and surface to surface transfers The MDS identified the resident was occasionally incontinent of urine.

The resident's Activity of Daily Living and Urinary Status Care Area Assessments did not trigger.

The resident's care plan entry dated 9/30/14 included at times the resident went to the bathroom without asking for staff assistance and staff followed the resident's specific toileting plan.

The resident's care plan did not include the resident's specific toileting program nor did it direct staff where to locate the resident's specific toileting program.

A nurse's note dated 9/30/14 timed and timed 7:54 P.M. included the resident was on the floor. The resident stated he/she attempted to get from

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the bathroom to the bed, he/she could not reach the bed and fell down. Recommendation included nursing staff was to follow the resident's specific toileting program.

A nurses's note dated 10/24/14 and timed 5:42 P.M. included the resident was incontinent of bladder at time and was not on a bowel or bladder program.

The resident's clinical record did not support the facility performed a 3 day voiding diary or a bladder assessment.

The resident refused to allow the surveyor to observe his/her personal cares.

On 11/4/14 at approximately 9:45 A.M. direct care staff Q transferred the resident from the wheelchair to his/her bed. Observation revealed the resident had a slow and unsteady gait and the resident's right foot was shorter than his/her left foot.

On 11/4/14 at 7:57 A.M. administrative nursing staff D stated the resident was occasionally incontinent of urine and staff toileted the resident every 2 hours and as needed. Administrative nursing staff D stated the facility performed a bladder and program diary from 10/19/14 to 10/25/14 for MDS purposes. Administrative nursing staff D stated the facility did not perform a 3 day voiding diary and did not perform a bladder assessment.

On 11/4/14 at 9:06 A.M. licensed nurse H stated the resident was incontinent and he/she believed staff toileted the resident every 2 hours.

On 11/4/14 at 10:51 A.M. direct care staff Q

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F 315	Continued From page 17 stated the resident was incontinent of urine at times and staff toileted the resident every 2 hours. The facility's undated Voiding Diary Policy and Procedure included the facility completed a 3 day voiding diary for all residents upon admission, annually and with a significant change of condition. One the 3 day voiding diary was completed the results of the diary were used along with the urinary incontinent assessment to develop an individualized plan of care. The facility failed to thoroughly assess this resident's urinary incontinence for this resident who was continent of bladder when admitted to the facility,then became occassionally incontinent of urine.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 30 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide supervision and timely and effective interventions to prevent falls for 1 of 2 residents sampled for falls(#35), and failed to provide handrails without cracked jagged edges for one of one hallway on 2 of 2 days on site of survey.	F 323		

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F 323	Continued From page 18 Findings included: - On 11/3/14 at 9:13 A.M. during environmental tour on 11/4/14 at 10:20 A.M. revealed cracked plastic handrails with jagged edges on the main hallway handrails. On 11/4/14 at 10:50 A.M. with housekeeping/maintenance staff X and Y acknowledged the condition of the handrails. The facility failed to provide a policy and procedure for environmental maintenance. The facility failed to provide handrails without jagged edges for this main hallway. - Resident #35's quarterly Minimum Data Set (MDS) dated 10/29/14 identified the resident scored 12 (moderate impaired cognition) on the Brief Interview for Mental Status, required limited staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident had an unsteady gait and was only able to stabilize with staff assistance when moved from a seated to a standing position, walking, turning around, moving on/off the toilet and surface to surface transfers The MDS identified the resident had (2) non-injury falls since the prior assessment, was occasionally incontinent of urine and received an antidepressant, antipsychotic and antianxiety 7 of the 7 days during the assessment period. The resident's Fall Care Area Assessment (CAA) dated 3/29/14 documented the resident had a	F 323		

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history of polio (a disease that can affect nerves and lead to partial or full paralysis), the resident's right leg was smaller and shorter than his/her left leg and had a decrease of muscle tone in his/her right leg. The resident had an uneven gait, used a wheelchair for a mobility aide and normally pushed the wheelchair in front of himself/herself for added stability. The resident was also at risk for falls related to the use of psychotropic medications.

The resident's Fall Risk Assessments dated 2/21/14 and 5/26/14 identified the resident scored 9, on 8/10/14 the resident's fall risk score was 18 and on 10/26/14 the resident's score was 17. According to the legend a score of 10 or more represented the resident was at high risk for falls.

The resident's care plan dated 8/7/14 included the resident was at an increased risk of falling due to weakness and an unsteady gait at times. The facility performed a fall assessment every quarter and when the resident had a significant change in condition. The resident could not safely ambulate with his/her walker and staff assisted the resident with ambulation via a gait belt to help keep him/her mobile and safe from injury. The resident used a wheelchair the majority of the time to get around which he/she self propelled but staff assisted the resident if he/she was tired or needed to get somewhere quickly, Staff checked the resident's blood pressure if the resident was dizzy or seemed unsteady when he/she sat or stood up. Staff ensured the resident's call light was within reach, the resident might not always want to use it but staff reminded the resident he/she was safer if staff assisted the resident with getting out of bed or transferring to and from his/her wheelchair.

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Staff ensured the resident wore non-skid socks or shoes so his/her feet did not slip out from under him/her. Staff checked on the resident often when the resident was in his/her room. An entry dated 9/30/14 included at times the resident went to the bathroom without asking for staff assistance and staff followed the resident's specific toileting plan. An entry dated 10/1/14 included staff often reminded the resident to activate his/her call light prior to transferring. An entry dated 10/26/14 included a staff member stayed with the resident while he/she smoked.The resident did get cigarettes from other residents without staff knowledge and if staff observed the resident in the smoking room without staff, staff reminded the resident he/she needed to have a staff member present for his/her safety.

The resident's care plan did not include the resident's specific toileting program nor did it direct staff where to locatethe resident's specific toileting program.

A late entry nurse's note (NN) dated 4/22/14 and timed 9:42 A.M. included the resident ambulated to the nursing station and reported he/she tripped outside in the smoking area. The resident had abrasions on his/her left bicep (arm), left forehead and a small skin tear to his/her left 5th finger. The facility fall investigation form included the resident tripped outside in the smoking area and landed face first on a concrete bock. Interventions/Recommendations implemented on 5/27/14 included staff reminded the resident to use his/her wheelchair at all times, staff kept the resident's room and smoking area clear of clutter and provided assistance as needed.

A NN dated 5/26/14 and timed 11:07 A.M.

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included a late entry timed 2:00 P.M. that included the resident sat on the floor on his/her buttock in the middle of the hallway by the television room's entrance. The facility's fall investigation form included a conclusion dated 6/8/14 that documented the resident refused to properly use his/her wheelchair. Intervention/Recommendation included staff educated the resident on the proper way to use his/her wheelchair and staff provided continuous monitoring when the resident used his/her wheelchair.

A NN dated 5/30/14 and timed 12:59 P.M. included the resident sat on the floor in his/her room. The resident stated he/she slipped as he/she entered his/her room and landed on his/her buttocks. The facility's investigation form included a conclusion dated 6/10/14 that included the resident slipped while walking around his/her wheelchair. Intervention/Recommendation implemented 6/10/14 included staff were to educate the resident to use his/her wheelchair correctly to avoid falling. Staff were to propel the resident to meals/smoking room when staff observed the resident push his/her wheelchair.

A NN dated 6/3/14 and timed 1:48 P.M. included the resident stated he/she lost his/her balance and went to the floor on his/her right side. Intervention included staff encouraged the resident to use the wheelchair for locomotion.

A NN dated 8/3/14 and timed 10:59 P.M. included the resident was on his/her knee in the door way and another resident assisted the resident up. Intervention/Recommendation included staff monitored the resident when he/she was in the hallways, staff encouraged the resident to ask for staff assistance with transfers or if he/she had

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F 323	Continued From page 22 increased weakness and direct care staff performed 1 on 1 assistance with ADLs. A NN dated 8/10/14 and timed 9:34 P.M. documented the resident sat on the floor between a peer's bed and dresser. The resident stated he/she took himself/herself off the toilet, lost his/her balance and sat down on the floor. Intervention/Recommendation included the facility continued to educate the staff the importance of assisting the resident with his/her ADLs and staff encouraged the resident to activate his/her call light when he/she needed assistance. A NN dated 8/17/14 and timed 1:07 P.M. included the resident stated he/she was in the bathroom, lost his/her balance and lowered himself/herself to the floor. The resident had a 5 centimeter wide purple colored non-raised area on his/her left forearm. A NN dated 9/30/14 timed and timed 7:54 P.M. included the resident was on the floor. The resident stated he/she attempted to get from the bathroom to the bed, he/she could not reach the bed and fell down. Recommendation included nursing staff was to follow the resident's specific toileting program to help reduce falls. A NN dated 10/26/14 and timed 2:25 P.M. included the resident sat on the ground outside. The resident voiced he/she tripped over his/her foot pedals on his/her wheel chair. Intervention included staff was to stay with the resident when the resident was in the smoking areas. On 11/3/14 at 9:30 A.M. direct care staff O assisted the resident to the smoke room. Observation revealed direct care staff O stayed	F 323		

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with the resident while the resident smoked. During interview with direct care staff O at that time he/she stated since the resident's last fall, staff stayed with the resident while he/she smoked.

On 11/4/14 at 8:45 A.M. the resident sat in his/her wheelchair and smoked in the smoke room. Observation revealed a staff stood outside of the smoke room door.

On 11/4/14 direct care staff transferred the resident from the wheelchair to his/her bed. Observation revealed the resident had a slow and unsteady gait and the resident's right foot shorter than his/her left foot.

On 11/4/14 at 7:57 A.M. administrative nursing staff D stated the resident was at risk for falls, staff reminded the resident to activate his/her call light for assistance, the resident still got up on his/her own and the resident was forgetful. Administrative nursing staff D stated the resident was on a restorative nursing program and staff ambulated with the resident twice a day.

On 11/4/14 at 9:06 A.M. licensed nurse H stated the resident was at risk for falls and since the resident's last fall staff remained with the resident when he/she she smoked. Licensed nurse H stated staff educated the resident not to stand without staff assistance and staff ensured the resident wore shoes and non-skid slippers. Licensed nurse H stated he/she believed staff toileted the resident every 2 hours.

On 11/4/14 at 10:30 A.M. administrative nursing staff D stated from July 12, 2014 until the first of August 2014 staff provided 1 on 1 assistance to the resident at all times. Administrative nursing

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F 323	Continued From page 24 staff D stated starting around the first of August 2014 staff provided supervision which included staff educated the resident to use his/her call light and to not stand without staff assistance. Administrative nursing staff D stated the facility did not provide 1 on 1 assistance with smoking from the first of August 2014 until 10/26/14. Administrative nursing staff D stated the resident had not used the walker since 7/12/14 and now sat in the wheelchair at all times. The facility's undated Accidents and Occurrences Policy and Procedure included each resident received adequate supervision and assuasive devices to prevent occurrences. The facility failed to implement timely and effective fall interventions for this resident with a history of falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 25 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents. Based upon record review and interviews the facility to implement timely bowel management interventions for 1 of 5 residents reviewed for medications, (#29) resident with a history of constipation (infrequent or hard to pass bowel movements). Findings included: - Resident #29's computerized diagnosis of constipation. The resident's quarterly Minimum Data Set (MDS) dated 9/24/14 included the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use and personal hygiene. The resident's Antipsychotic Care Area Assessment dated 3/15/14 included the resident received antipsychotic, antianxiety, and antidepressant medications and staff monitored the resident for side effects of the medications each shift. The resident's care plan dated 7/7/14 addressed the resident received psychotropic medications	F 329		

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and staff administered the medications as the physician ordered. Staff monitored and documented if the resident experienced side effects from the medications including constipation.

Review of the resident's current computerized physician's orders revealed the resident's medications included Buspirone HCL 20 milligrams (mg) three times a day for anxiety, Seroquel 600 mg daily for Schioaffective Disorder (SAD-psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Benztropine Mesylate 1 mg daily for SAD, Haloperidol 10 mg once a day and 5 mg twice a day for SAD, Prilosec 20 mg daily for GERD (gastroesophageal reflux disease-too much acid in the stomach) and Trazadone 75 mg daily for insomnia (difficulty sleeping). According to literature from the U.S. National Library of Medicine dated 10/1/14 all of the above medications had a side effect of constipation. The resident's current computerized physician's orders included the resident received Colace (used to treat constipation) 100 mg two times a day.

Review of the resident's August and September 2014 bowel monitoring log lacked documentation to support the resident had a bowel movement (BM) from 8/10/14 until 8/15/14 at 4:08 PM (duration of 5 days). The review also lacked documentation to support the resident had a BM on 8/19, 8/20, 8/21, 8/22, or 8/23/14 (duration of 5 days). There was no documentation the resident had a BM on 9/13, 9/14, 9/15 or 9/16/14.

Review of the resident's Medication Administration Record revealed the resident had

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a physician's order to receive Dulcolax 10 mg suppository rectally one time daily as needed for constipation. Further review revealed the resident received the suppository on 8/14/14 at 6:42 P.M. The review did not support the resident received the as needed laxative any other time time during the month of August or September.

A nurse's note (NN) dated 8/13/14 and timed 5:26 A.M. documented the resident had not had a BM in 3 days, staff offered the resident prune juice and the resident chose not to receive it. The note did not include staff offered the resident the as needed laxative suppository.

A NN dated 8/15/14 and timed 2:37 A.M. documented the resident did not have a BM in 5 days, staff administered the as needed laxative suppository the night of the 14th and stated no results and staff offered the resident prune juice.

A NN dated 8/15/14 and timed 5:47 P.M. documented staff gave the resident 8 ounces of prune juice during the breakfast meal, the resident stated the prune juice was not effective and the resident stated he/she did not have a BM that shift.

The resident transferred from the facility on 10/31/14.

On 11/4/14 at 9:15 A.M. licensed nurse H stated if a resident did not have a BM in 2 days, staff offered prune juice and the facility had standing physician's orders for a laxative suppository if needed. Licensed nurse H stated the night shift nurse ran the BM reports, offered residents prune juice or implemented other interventions as needed.

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F 329	Continued From page 28 On 11/4/14 at 10:30 A.M. administrative nursing staff D confirmed the facility offered the laxative once during the time frame when the resident did not have a BM for 5 days. Administrative nursing staff D confirmed the resident's care plan did not address the resident's constipation. On 11/4/14 at 10:47 A.M. direct care staff Q stated direct care staff checked with residents each shift to see if he/she had a BM and documented the results on the ADL sheets as well as in the resident's electronic BM log. On 11/4/14 at 11:11 A.M. nursing administrative staff D stated if the resident did not have a BM in 2 days,on the 2nd day staff offered prune juice, pushed fluids, assessed the resident's bowel sounds and discomfort and on day 4 notified the resident's physician. The facility's undated Bowel Movement Monitoring Report included staff documented bowel movements in the electronic medical record. Nurses monitored the occurrence of, or lack of, bowel movements at the beginning of each shift and applied interventions as needed. The facility failed to provide timely and effective interventions for this resident with a history of constipation and received medications with constipation as a side effect.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		

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This Requirement is not met as evidenced by:
The facility had a census of 30 residents with one central kitchen. Based upon observation, record review and interview the facility failed to maintain proper food temperatures.

Findings included:

- During Stage 1 of the survey (10/29/14 and 10/30/14) 5 residents expressed concern food was not served at the proper temperature.

On 10/29/14 review of the facility's dining times included the facility served lunch from 11:15 A.M. until 12:15 P.M.

Review of the facility's food temperature log on 11/4/14 at 9:51 A.M. for the month of October 2014 revealed food temperatures ranged from 140 degrees F to 200 degrees F. Further review revealed only 1 temperature taken per food item during the serving time.

On 11/3/14 at 11:05 A.M. dietary staff DD recorded the temperature of the foods from the steam table. The temperature of the noodles were 164 degrees Fahrenheit (F) and the temperature of the beef and noodles were 168 degrees F. At 11:30 A.M. per the surveyor's request dietary staff DD reported the temperature of the noodles was 158 degrees F and the beef and noodles were 148 degrees F. At 12:00 P.M. per the surveyor's request dietary staff GG stated the temperature of the beef and noodles was 130 degrees and the noodles were 110 degrees F. Observation revealed staff had just served residents food from the steam table.

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F 364	Continued From page 30 On 11/3/14 at 12:00 P.M. direct care staff Q stated 12 residents had not received the lunch meal. At 12:23 P.M. direct care staff Q stated (2) residents received the lunch meal between 12:00 P.M. to 12:15 P.M. On 11/4/14 at 9:51 A.M. dietary staff DD stated staff recorded the temperature of the food at the beginning of the meal. Dietary staff DD stated he/she randomly checked the temperature of the food during the serving time but did not document those temperatures. The facility's Monitoring Food Temperature for Meal Services Policy and Procedures included staff checked the food temperature for all hot and cold foods prior to placing them on the serving line and rechecked the temperatures every half hour. Any food not at the correct temperature was not served and appropriate corrective actions were taken. The facility failed to maintain proper temperatures of food during serving time.	F 364		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 31 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 30 residents. Based on observation, record review, and interview the facility failed to demonstrate proper hand hygiene and failed to utilize precautions to minimize transmission of infection to three resident rooms. Findings included: - Observation on 10/30/14 at 8:11 A.M. housekeeping staff Z stood by a resident's doorway and put items away on his/her housekeeping cart, wearing gloves, he/she pushed the cart to another residents room. He/she did not remove his/her gloves, swept the	F 441		

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F 441	Continued From page 32	F 441		

floor of the room and sprayed the bedroom floor with Green Earth Bioactive Betco Floor Cleaner, sprayed the toilet and bathroom with Betco Sure Bet Restroom Cleaner. He/she used a floor mop with attachable pads to wipe the floor. The furniture, sink, walls, call buttons, and mirror were not cleansed and the beds was not moved for cleaning in the residents room. He/she changed the mop pad, wiped the bathroom floor, and used a rag to clean the toilet. He/she mopped the dirt into the hallway and picked it up with a paper towel. The soiled mop pads were put into a bucket and the trash containers from the room were emptied into the trash container of the housekeeping cart. He/she did not change his/her gloves or wash his/her hands and moved the cleaning cart to another residents room at 8:26 A.M. He/she did not place a "Wet Floor" sign in front of the residents room after mopping.
He/she cleaned the second room as the first, did not change gloves or wash his her hands, and moved his/her cleaning cart to the next residents room at 8:42 A.M. He/she cleaned the third room as the first and second and did not change gloves or wash his/her hands after. He/she moved the housekeeping cart to another residents room and removed his/her gloves during an interview. "Wet Floor" signs were not placed during or after three room cleanings.

On 10/30/14 with housekeeping staff Z stated he/she did not place "Wet Floor" signs after moping the residents rooms. The residents could see his/her housekeeping cart and knew that the floors were damp. He/she stated gloves were changed every 3 rooms because that was when the gloves were dirty.

On 11/4/14 at 1:32 P.M. maintenance and housekeeping staff X stated he/she expected

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F 441	Continued From page 33 housekeeping to move the beds, sweep under the bed, clean the sink and bathroom, walls, call lights, and bed rails. He/she stated staff should at least change their gloves at every room. On 11/4/14 at 8:32 A.M. administrative nursing staff D stated housekeeping staff should change gloves and wash their hands everytime they change rooms and after touching dirty items. The undated facility policy for Hand Washing and Glove Usage recorded gloves were disposable and for single use only, and hands should be sanitized before applying and after removing gloves. Staff should use an Alcohol-Based instant hand Sanitizer upon entering a residents room and after handling soiled equipment. The facility failed to demonstrate proper hand hygiene and failed to utilize precautions to minimize transmission of infection.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility reported a census of 30 residents. Based on observation and interview, the facility failed to maintain an external environment for residents on 1 of 1 day on site of survey. Findings included:	F 465		

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F 465	Continued From page 34 - Environmental observation on 11/4/14 at 10:20 A.M. to 10:50 A.M. revealed the resident's outdoor smoking area was littered with cigarette butts and disposable plastic cups, a broken gutter on the North side of the building, an air conditioner (AC) external screen had detached from the building and layed on the ground, a decorative window shutter pulled away from the building, paint was peeling around the windows. Cable/antenna wires were detached and dangled cable/antenna wires on the north side of the building, a plastic covered love seat and an external window screen had multiple large holes. Throughout the environmental tour on 11/4/14 maintenance/housekeeping staff X and Y acknowledged the above concerns. The facility failed to provide a policy for facility's general building maintenance. The facility failed to maintain the external environment of the building for the residents.	F 465		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		

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F 520	Continued From page 35 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility identified a census of 30 residents. Based on record and interview the facility to maintain a quality assessment and assurance committee that met at least quarterly to identify issues that required plans of action. Findings included: - Review of the sign in sheets for the Quality Assessment and Assurance committee (QAA) provided by the facility on 11/4/14 at 10:15 A.M. revealed the facility held 1 meeting in the last year. Interview on 11/3/14 at approximately 12:00 P.M. with administrative staff A revealed the facility did not hold quarterly QAA meeting due to the medical director not being available. Staff A reported if the medical director was not able to attend the facility did not hold a QAA meeting. Interview on 11/4/14 at 1:54 P.M. with administrative staff A revealed the facility did not hold QAA meetings at least quarterly due to the medical director's schedule. The facility failed to provide a policy regarding	F 520		

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F 520	Continued From page 36 QAA as requested on 11/4/14 at 12:05 P.M. The facility failed to maintain a QAA committee that met at least quarterly to identify and address issues for resident in the facility.	F 520		